STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445075	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **02/20/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF MADISON	**431 LARKIN SPRING RD** **MADISON, TN 37115**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Life Safety revisit survey was conducted on 02/20/2019 for all previous deficiencies cited on 01/13/2019. All deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

45th day 3-1-19 70th day 3-26-19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/17/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445075	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF MADISON	431 LARKIN SPRING RD MADISON, TN 37115

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K 000	INITIAL COMMENTS Stories: 1 Construction Type: NFPA, V (000); IBC, V unprotected No plans available on site Constructed: 1974 Sprinklered: Yes Census: 59 Certified beds: 102 A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 01/13/2019. During this Life Safety Survey, Signature of Madison was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 232 SS=D	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by:	K 232	**K 232** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? On 1/16/19, Plant Ops Director removed the obstruction (floor scale) from the corridor. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/2/19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445075	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/13/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF MADISON	**431 LARKIN SPRING RD** **MADISON, TN 37115**

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K 232	Continued From page 1 Based on observation, the facility failed to maintain the aisle, corridor or ramp width. The findings included: Observation on 01/13/2019 at 9:02 AM, revealed a wheel chair scale in the corridor door at the east hall exit by room 42. NFPA 101, 19.2.3.4 (2012 Edition) The Maintenance Director was present when this deficiency was identified and the Administrator acknowledged this deficiency during the exit conference on 01/13/2019.	K 232	On 1/13/2019, all other exit corridors were checked to ensure there was no obstruction; No concerns were identified. What measures will be put into place or what system changes you will make to ensure the deficient practice does not recur? On 1/13/2019, the Plant Ops Director received education from Life Safety Specialist during the exit interview regarding the maintaining of corridor exits and to always be unobstructed. On 1/21/2019, the Plant Ops Director permanently relocated the floor scale and ensured there was a sign notifying staff/visitors that the corridor must remain unobstructed. Beginning on 1/21/19, the Plant Operations Director will spot check corridors x 30 days to ensure they are unobstructed, fixing any identified concern immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? A review of the above system change, education, and monitoring for Aisle, Corridor, and Ramp Width will be reviewed during the Quality Assurance Process Improvement meeting monthly x2 months for appropriate monitoring to ensure deficient practice does not recur and/or offer any additional suggestions until substantial compliance is achieved. At that time, the QAPI committee will determine the recurrence of such audits and monitoring.	2-1-19
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through	K 324		

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	445075	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 324	Continued From page 2 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to protect the cooking facilities. The findings included: Interview with kitchen staff member #1 on 01/13/2019 at 1:14 PM, revealed the staff member was not knowledgeable of the proper fire control procedure for fires under the kitchen hood including the manual activation of the hood suppression system and the use of the hood suppression system as the primary means of fire extinguishment. NFPA 101, 19.3.2.5.1 (2012 Edition) NFPA 96, 10.5.7 (2011 Edition) NFPA 96, 10.2.1 (2011 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 01/13/2019.	K 324	**K324** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No resident were cited as being affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No resident were cited as being affected by the deficient practice. What measures will be put into place or what system changes you will make to ensure the deficient practice does not recur? On 1/13/2019, the facility kitchen staff were inserviced by Plant Ops Director on the proper fire control procedure for fires under the kitchen hood including how to manually activate this system. Beginning on 1/13/2019, new kitchen staff hired will receive specific instruction on the hood suppression system during Orientation. The Plant Ops Director will do a fire drill in the kitchen x2 months to ensure competency and will re-educate if indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist	K 363		

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K 363	Continued From page 3 the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain corridor doors. The findings included: Observation on 01/13/2019 at 8:55 AM, revealed the corridor door to the west dining room did not resist the passage of smoke and had a gap at the	K 363	A review of the above system change audits, education, and monitoring for Cooking Facilities will be reviewed during the Quality Assurance Process Improvement meeting monthly x2 months for appropriate monitoring and follow up to ensure deficient practice does not recur and/or offer any additional suggestions until substantial compliance is achieved. At that time, the QAPI committee will determine the recurrence of such audits and monitoring. **K363** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? On 1/13/2019, the Plant Ops Director observed facility doors to ensure requirements are met, with no other concerns at that time. What measures will be put into place or what system changes you will make to ensure the deficient practice does not recur? On 1/13/2019, the Plant Ops Director notified Corporate Office personnel to request a new door as the door was noted to be milled incorrectly from the manufacturer upon installation. Beginning on 1/13/2019,	2.7.19

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K 363	Continued From page 4 top of the door larger than a 1/2 inch. NFPA 101, 19.3.6.3.1 (2012 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 01/13/2019.	K 363	the Plant Ops Director will ensure doors are checked weekly x4 weeks to ensure there are no noticeable gaps and doors are smoke resistant and will immediately address any concerns if indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to maintain the heating, ventilation, and air conditioning system. The findings included: Document review on 01/13/2019 at 10:10 AM, revealed the facility failed to provide documentation of the 4 year fire damper inspection. NFPA 101, 19.5.2.1 (2012 Edition) NFPA 101, 9.2.1 (2012 Edition) NFPA 90A, 5.4.7.1 (2012 Edition) NFPA 80, 19.4 (2010 Edition) The Maintenance Director was present when this deficiency was identified and the Administrator	K 521	A review of the above system change audits and monitoring for Corridor- Doors will be reviewed during the Quality Assurance Process Improvement meeting monthly x2 months for appropriate monitoring and discussion to ensure deficient practice does not recur and/or offer any additional suggestions until substantial compliance is achieved. At that time, the QAPI committee will determine the recurrence of such audits and monitoring. **K 521** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were referenced as being affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents had the potential to be affected by the deficient practice.	2.7.19

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K 521	Continued From page 5 acknowledged these deficiencies during the exit conference on 01/13/2019.	K 521	What measures will be put into place or what system changes you will make to ensure the deficient practice does not recur?	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to conduct maintenance, inspection & testing of doors. The findings included: Document review on 01/13/2019 at 10:05 AM, revealed the facility failed to conduct the annual fire door inspection during 2018. NFPA 101, 19.7.6 (2012 Edition) NFPA 101, 4.6.12 (2012 Edition) NFPA 101, 4.6.12.4 (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition) NFPA 80, 5.2.3 (2010 Edition) The Maintenance Director was present when these deficiencies were identified and the	K 761	On 1/13/2019, Plant Ops Director contacted the service company and received the referenced documentation. The documentation will be kept on-site moving forward in a designated binder for quick access. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? A review of the above system change for HVAC citation will be reviewed during the Quality Assurance Process Improvement meeting monthly x1 month to ensure proper documentation is accessible and obtained and committee will determine substantial compliance. At that time, the QAPI committee will determine the recurrence of such monitoring. **K761** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were mentioned as being affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	2-1-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 761	Continued From page 6 Administrator acknowledged these deficiencies during the exit conference on 01/13/2019.	K 761	No other residents had the potential to be affected by the deficient practice. What measures will be put into place or what system changes you will make to ensure the deficient practice does not recur? On 1/13/2018, the Plant Operations Director was inserviced by the facility Administrator on conducting this inspection annually. Beginning on 1/16/2019, the Plant Operations Director began conducting annual fire door inspections in the facility, addressing any concern in a timely manner. The Plant Operations director will ensure his TELS audit platform has a scheduled inspection annually and will conduct inspections timely moving forward. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? A review of the above system change audits and monitoring for *Maintenance, Inspection & Testing - Doors* will be reviewed during the Quality Assurance Process Improvement meeting monthly x1 month for appropriate monitoring and discussion to ensure deficient practice does not recur and/or offer any additional suggestions until substantial compliance is achieved. At that time, the QAPI committee will determine the recurrence of such audits and monitoring.	2.7.19

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	445075	A. BUILDING _____ B. WING _____	R 02/20/2019

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{E 000}	Initial Comments A Emergency Preparedness revisit survey was conducted on 02/20/2019 for all previous deficiencies cited on 01/13/2019. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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E 000	Initial Comments A Emergency Preparedness Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 01/13/2019. During this Emergency Preparedness Survey,Signature of Madison was not found in substantial compliance with the requirements for participation in Emergency Preparedness Regulations for Long-Term Care Facilities, Federal CFR §483.73. The requirement at 42 CFR, §483.73 are NOT MET as evidenced by:	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency	E 006	E 006 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No resident was mentioned as being affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were affected by the deficient practice. What measures will be put into place or what system changes you will make to ensure the deficient practice does not recur? On 1/13/2019, the Plant Operations Director corrected the community-based risk assessment to include the assessment of a missing client (Elopement). The system change will be to always include a missing client (Elopement Risk) into community-based hazards approach in the facility All Hazards assessment. How the corrective action(s) will be monitored to ensure the deficient practice	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2/2/19

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E 006	Continued From page 1 events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to complete the risk assessment utilizing an all-hazards approach per the requirements of Federal CFR §483.73. The finding included: Interview on 01/13/2019 at 1:40 PM, revealed the facility's facility based/community based risk assessment for the emergency preparedness program did not utilize an all-hazards approach including the assessment of missing client. The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 01/13/2019.	E 006	will not recur; i.e., what quality assurance program will be put into place? A review of the system change for *Plan Based on All Hazards Risk Assessment* will be reviewed and discussed during the Quality Assurance Process Improvement meeting monthly x1 month for appropriate monitoring to ensure the deficient practice does not recur and/or offer any additional suggestions until substantial compliance is achieved. At that time, the QAPI committee will determine the recurrence of such audits and monitoring.	2.7.19
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:	E 032	**E 032** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were cited as being affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No residents were cited as being affected by the deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445075	A. BUILDING _____ B. WING _____	01/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF MADISON	431 LARKIN SPRING RD MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 032	Continued From page 2 (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include policies and procedures for primary and alternate means for communicating with facility staff, Federal, State, tribal, regional, and local emergency management agencies in the emergency preparedness program per the requirements of Federal CFR §483.73. The finding included: Interview on 01/13/2018 at 1:50 PM, revealed the facility had no record of polices and procedures for alternate means for communicating with Federal, State, tribal, regional, and local emergency management agencies during an emergency. The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 01/13/2019.	E 032	What measures will be put into place or what system changes you will make to ensure the deficient practice does not recur? On 1/13/2019, Facility Administrator inserviced the Plant Operations Director regarding alternative means of communication with facility staff and external agencies during an emergency situation. On 1/21/2019, the Plant Operations Director revised the current communication document to include the necessary agencies contact information. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? A review of the system change (updated document) for *Primary/Alternate Means of Communication* will be reviewed and discussed during the Quality Assurance Process Improvement meeting monthly x1 month to ensure the deficient practice does not recur and/or offer any additional suggestions until substantial compliance is achieved. At that time, the QAPI committee will determine the recurrence of such audits and monitoring.	2.7.19